American Brain Tumor Association®

The Glenn Garcelon Fund, an ABTA Financial Assistance Program Grant Application

The Glenn Garcelon Fund / ABTA Financial Assistance Grant exists to help ease the financial burden caused by Central Nervous System (CNS) tumors. The Grant covers certain expenses and/or bills that the patient has. If awarded a grant, payment will be made by check to the company (e.g., property manager, mortgage, medical bills, utilities) you have requested to be paid. Checks are not made payable directly to the patient or their loved ones.

Who is eligible?

If selected, the Glenn Garcelon Fund / ABTA Financial Assistance Grant is awarded to those who:

- Have a primary central nervous system (brain, spine, cranial nerves) tumor
- Reside in the United States (50 states and US territories)
- Have a yearly household income that is equal to or less than 500% of the US Federal Poverty Guidelines

What is the amount given to a qualified applicant?

Awarded grants are between $250 and $1000. The amount awarded depends upon the applicant's needs and circumstances, number of grant applications received by the ABTA, and the current grant funds available.

What is needed to apply for a grant?

To be considered for a grant, applicants are asked to complete and submit ALL of the following items:

1) Completed application form
2) Medical Provider form (p.9-10) -- Your medical provider must complete the form
3) Proof of household income (in PDF format)
    - First two pages of signed copy of 1040 income tax return for the past 2 years (redacted social security numbers) for **all non-dependent members of the household**; or, if you do not file tax returns or have had a change in your employment, submit 3 months' worth of copies of pay checks / stubs; unemployment checks; or social security, public assistance, and

other benefit notifications for **all non-dependent members of the household**.
    - If the patient is a minor, financial records of parent(s)/guardian(s) must be submitted.
4) Copies of bills (in PDF format)
    - Copies of up to three current bills that you are requesting be paid. Must include account number and mailing address of vendor.
    - If you are requesting help with rent, submit a copy of your rental lease that includes the patient's name, amount of rent, account number, landlord's or property manager's name, and mailing address where payments are made.
5) Medical information
    - Copy of patient's pathology report (if biopsy/surgery performed)
    - Copy of most recent MRI report (NOT scan)
6) Two high quality photos of the patient in jpg format.
    - If photos are sent separately from the application, please include the patient's name.
    - Do not send a copy of a driver's license or other ID card, and do not send pictures of patient's head following surgery.

How do I submit the grant application?

Please complete this application by filling out this form electronically or by printing it out and handwriting your answers. Additional documents (e.g., tax return info, path report, photos) can be emailed to FinancialAssist@abta.org or mailed to:

American Brain Tumor Association
Attn: Financial Assistance Program
8550 W. Bryn Mawr Ave, Ste 550
Chicago, IL 60631

When are grants awarded?

Applications must be received in their entirety no later than the 15th to be considered for that month (except for December, when the deadline to receive everything is the 5th).

Please add FinancialAssist@abta.org to your contact list. We will send an email when your application is received and let you know if we need any additional items. By adding our email address to your contact list, you will ensure that our communication does not end up in your junk mail file and keep your application from moving forward in the review process.

Have other questions? Contact the ABTA at FinancialAssist@abta.org or call 800-886-2282.

Patient information

- Full legal name _____
- Preferred first name _____
- Phone number _____
- Email address_____
- Street address_____
- City_____
- State_____
- Zip Code_____
- Date of birth_____
- Gender

  ☐ Male
  ☐ Female
  ☐ Non-binary/third gender
  ☐ Prefer to self-identify

- Your or your loved one's tumor type_____
- Which best describes where the patient is concerning treatment? (check all that apply)

  ☐ Newly diagnosed
  ☐ Exploring treatment options
  ☐ In treatment
  ☐ Watch & wait
  ☐ Survivorship
  ☐ Hospice/End of life care

- How did you learn about the Glenn Garcelon Fund / ABTA Financial Assistance Grant? (please check)
  ☐ Glenn Garcelon Foundation
  ☐ ABTA website

- ☐ Brain Tumor Network
- ☐ Connections/Inspire
- ☐ ABTA Email
- ☐ Family/Friend
- ☐ Online search
- ☐ Referral/Healthcare Professional
- ☐ ABTA's CareLine
- ☐ Social media
- ☐ Support group
- ☐ Other (please specify) _____

Emergency Contact Information

- Spouse or significant other's full name_____
- Phone number_____
- Email address_____
- Street address_____
- City_____
- State_____
- Zip code_____
- Emergency contact's full name (if different from above)_____
- Relationship to patient_____
- Phone number_____
- Email address_____
- Street address_____
- City_____
- State_____

- Zip code_____

Please complete this section if the patient is a minor (age 0-17)

- Name of parent or guardian #1_____
- Phone number_____
- Email address_____
- Street address_____
- City_____
- State_____
- Zip Code_____
- Name of parent or guardian #2_____
- Phone number (if different than above) _____
- Email address (if different than above) _____
- Street address (if different than above) _____
- City (if different than above) _____
- State (if different than above) _____
- Zip Code (if different than above) _____

Health Insurance

- Does the patient have health insurance?
  ☐ Yes
  ☐ No
- If yes, indicate the type of health insurance (check all that apply)
  ☐ Private
  ☐ Medicare
  ☐ Medicaid
  ☐ Supplemental (“Medigap”)
  ☐ VA/TRICARE

☐ Other (Please specify) _____

- What is the patient's annual deductible? _____

Household

- Number of people in patient's household_____
- Ages of people in household_____

- Number of people in patient's household who are dependent on either 1) the patient or 2) their spouse or significant other _____

- Number of employed people in the patient's household_____

- Number of non-dependent unemployed people in the patient's household_____

- Why are these people unemployed at this time?

- Have there been any significant changes in household members' employment since the patient's diagnosis?
  ☐ Yes (please explain) _____
  ☐ No

Financial Information

Household monthly income

- Is the patient currently employed?
  ☐ Yes (list employer's name) _____
  ☐ No

- Monthly income sources for all non-dependent household members
  - Salaries (gross)_____
  - Pensions_____
  - Social Security Supplemental Income (SSI)_____
  - Social Security Disability Insurance (SSDI)_____
  - Unemployment_____

- Short-term disability_____
- Long-term disability_____
- Public Assistance_____
- Financial assistance (e.g., charities, non-profits, crowdfunding)_____
- Support from family/friends_____
- Other (please specify)_____

- Total expected gross income for all living in the household this year_____

Household account balances (as of date of application) – Please complete for all non-dependent household members.

- Total checking account balances_____
- Total savings account balances_____
- Total investment (e.g., stocks, bonds, mutual funds) account balances_____
- Total account balances (add total balances from above)_____

Household monthly expenses – Please complete for all members of household, including dependents.

- Monthly rent or mortgage (include HOA fees, taxes, homeowner's insurance if applicable)_____
- Total monthly utility bills (e.g., gas, electric)_____
- Total monthly phone/internet bills_____
- Total monthly automobile payments_____
- Total monthly health insurance costs_____
- Total other insurance costs (e.g., auto, home)_____

- Other significant expenses_____

- Total monthly expenses (add total expenses from above)_____

Household current debts (as of date of application) – Please complete for all non-dependent household members.

- Current total credit card balances_____

- Current total medical bill balances_____

- Current total loan balances_____
    - List loan type(s)

- Other expenses/debts
    - _____
- Total current debt (list total debt balances from above)_____

Top expenses/bills

Please list up to 3 expenses and/or bills, including the amount you would like the Grant to pay for and list them in order of priority:

1. _____

2. _____

3. _____

Signature

By signing below, I attest that the information contained in this application is true and accurate. I also agree to the terms of the Glenn Garcelon Fund / ABTA Financial Assistance Grant as listed above and as stated by representatives of the American Brain Tumor Association. I also understand that my grant application will not be considered unless it is fully completed and that all required items/documents have been submitted to the American Brain Tumor Association. Further, I understand that completing this application does not guarantee that I or my loved one will receive a financial grant.

Signature: _____

Date: _____

- Full name of person completing this application (print/type)_____

- Relationship to patient*_____

* If someone other than the patient, family member, spouse, or health care provider completes this application, we will need a notarized Power of Attorney, specific to the state you reside in, for us to discuss this patient and the grant application with you.

If awarded a grant, I agree to allow the patient's picture and/or story to be used by the ABTA website and the Glenn Garcelon Foundation website to help raise awareness. (please select)

☐ Yes
☐ No

Personal story (optional)

If you are living with a brain tumor diagnosis, we would like to know more about you. Or, if you are completing this application on behalf of the person diagnosed with a CNS tumor, please use the space below to tell us more about that person. Please use the space below to tell us more about yourself. Your story can be about anything – not necessarily about the CNS tumor experience.

The Glenn Garcelon Fund, an ABTA Financial Assistance Program Grant
Medical Provider Form

Your responses will enable the applicant to be eligible for a financial assistance grant. Please complete this form in its entirety. **This form must be filled out by a Physician, Advanced Practice Provider, Registered Nurse, or Licensed Social Worker, and returned to the patient seeking assistance.**

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- Patient's name_____
- Patient's DOB_____
- Date of diagnosis_____
- CNS tumor type and grade_____
- Number of tumor recurrences_____
- Which treatments has the patient received

☐ Surgery and/or biopsy
☐ Radiation therapy
☐ Chemotherapy
☐ Clinical trial
☐ Tumor treating fields
☐ Palliative
☐ Other (please specify)_____

- Hospital, medical center, or clinic name_____

Physician's or Advanced Practice Provider's (e.g., neuro-oncologist) name andcredentials (please print)_____

- Provider's street address_____
- Provider's city _____
- Provider's state_____
- Provider's zip code_____
- Provider's phone number_____
- Provider's email_____
- How often does the provider see the patient? _____
- In the provider's opinion, is the patient able to work at this time?

☐ Yes
☐ No

Full name and credentials of person completing this application (print/type)_____

Signature: _____

Date: _____

Phone number (if different from above) _____

Email address (if different from above)_____

If possible, please include a brief statement on the patient's medical condition.

If you have any questions, please email FinancialAssist@abta.org or call 1-800-886-2282

All information provided in this form is strictly confidential and used solely to administer a financial assistance grant to the patient identified above. This information will only be used by the American Brain Tumor Association and the Glenn Garcelon Foundation.